Iowa Medicaid Enterprise

Documentation Standards
2012

Agenda

- Iowa Administrative Code
- PI (Program Integrity)reviews
- Overview of Federal oversight
- Questions & answers

Iowa Administrative Code

www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Rules/441-79.pdf

441- 79.3(249A):

Maintenance of Records by Providers of Service

- Providers shall maintain complete and legible records as required in this rule.
- Failure to maintain records or to make records available to the department or its representative may result in claim denial or recoupment.

79.3(1) Financial (fiscal)records

- Provider will maintain records to:
  - Support the reimbursement rate and
  - Support each item billed to Medicaid
- A financial record does not constitute a medical record.

441-79.3(2) Medical (clinical) records

79.3(2) *Medical (clinical) records*

- Provider shall maintain complete and legible medical records for each service
- Required records will include records required to maintain license in good standing

79.3(2)*a Definition.*

- The provision of each service and each activity billed to the program; **and**
- First and last name of the member receiving the service.

79.3(2)*b Purpose*

- The Medical record shall provide evidence that the service provided is:
  - Medically necessary;
  - Consistent with the member's condition; and
  - Consistent with professionally recognized standards of care

79.3(2)*c Components*

- The four components of a medical record
  - Identification
  - Basis for coverage
  - Service documentation
  - Outcome of service
- These will be defined over the next several slides

79.3(2)*c Components* (continued)

- **Identification**
  - Each page or separate electronic document:
    - Member's first and last name
  - Associated within the medical record:
    - Medical assistance ID number
    - Date of birth

79.3(2)*c Components* (continued)

- **Basis for Service**
  - Medical record shall reflect:
    - The reason for performing the service
    - Substantiate medical necessity
    - Demonstrate level of care
- General guidelines are outlined on the next 3 slides
  - They may not apply to every povider

79.3(2)*c Components* (continued)

- **Basis for service #1**
  - The member's complaint, symptoms, and diagnosis.
  - The member's medical or social history.
  - Examination findings.
  - Diagnostic test reports, laboratory test results, or X-ray reports.

79.3(2)*c Components* (continued)

- **Basis for service # 2**
  - Goals or needs identified in Plan of Care
  - Physician orders and any prior authorizations required for Medicaid payment.
  - Medication records, pharmacy records for prescriptions, or providers' orders.
  - Related professional consultation reports.
  - Progress or status notes for the services or activities provided.

79.3(2)*c Components* (continued)

- **Basis for service # 3**
  - All forms required by the department as a condition of payment for the services provided.
  - Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
  - The provider's assessment, diagnosis, etc
  - Any additional documentation necessary to demonstrate the medical necessity

79.3(2)*c Components* (continued)

- **Service Documentation (1)**
  - Record shall include information necessary to substantiate the provided service.
  - Specific procedures or treatments
  - Complete date of service with begin and end times

79.3(2)*c Components* (continued)

- **Service Documentation (2)**
  - Supplies dispensed
  - First name, last name & credentials, if any, of provider
  - Signature of provider or initials if signature log used
  - 24-hour care needs documentation, member's response, provider's name for each shift

79.3(2)*c Components* (continued)

- **Outcome of Service**
  - Medical record shall indicate:
    - Member's progress in response to services including:
      - Changes in treatment
      - Alteration of plan of care
      - Revision of diagnosis

79.3(2)*d Basis for service requirements for specific services*

- Specific requirements for more than 40 provider types
- Outlines documents needed by provider type for Program Integrity review

79.3(2)*e Corrections* to Documentation

- Correction made or authorized by provider of service
- Do not write over or obliterate; single line through and correct
- Indicate person making change, and person authorizing change (if applicable)
- If change affects paid claim, then amended claim is required

79.3(3) *Maintenance requirement*

- During time member is receiving services
- Minimum of 5 years from claim submission date (rolling 5 year retention)
- As required by licensing authority or accrediting body

441- 79.4(249A): Reviews Performed by Program Integrity

79.4(2)a *Audit or review of clinical & fiscal records by the department*

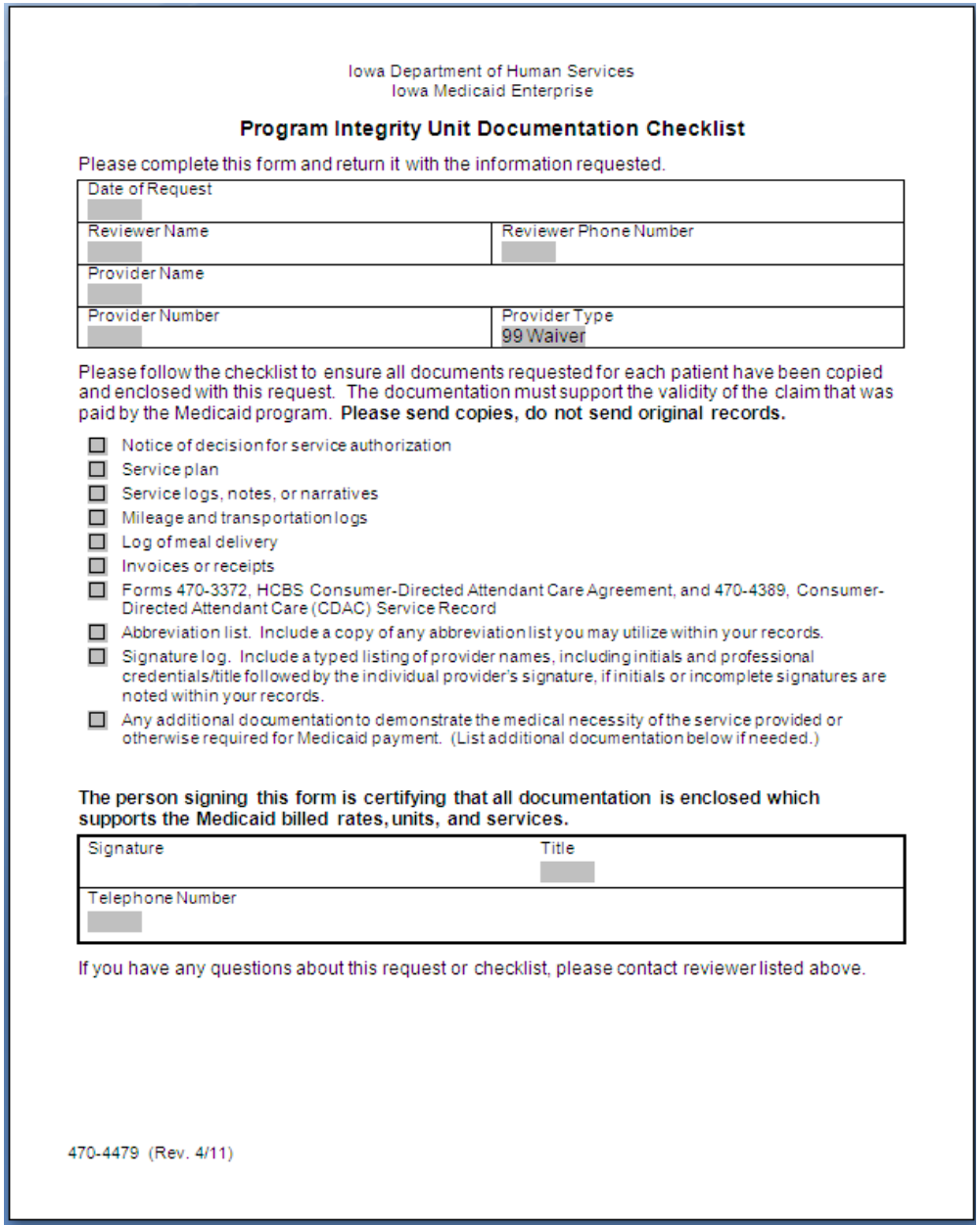
- Review/audit to determine:
  - If the department has correctly paid
  - If the provider has furnished billed services
  - If records substantiate submitted claims
  - If provided services were in accordance with policy

79.4(2)b *Audit or review of clinical & fiscal records by the department*

- Form 470-4479 Documentation Checklist

- Lists specific documents to be requested for Program Integrity review

Documentation Checklist



Iowa Department of Human Services
Iowa Medicaid Enterprise

Program Integrity Unit Documentation Checklist

Please complete this form and return it with the information requested.

Date of Request	
Reviewer Name	Reviewer Phone Number
Provider Name	
Provider Number	Provider Type 99 Waiver

Please follow the checklist to ensure all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program. **Please send copies, do not send original records.**

- ☐ Notice of decision for service authorization
- ☐ Service plan
- ☐ Service logs, notes, or narratives
- ☐ Mileage and transportation logs
- ☐ Log of meal delivery
- ☐ Invoices or receipts
- ☐ Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record
- ☐ Abbreviation list. Include a copy of any abbreviation list you may utilize within your records.
- ☐ Signature log. Include a typed listing of provider names, including initials and professional credentials/title followed by the individual provider's signature, if initials or incomplete signatures are noted within your records.
- ☐ Any additional documentation to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment. (List additional documentation below if needed.)

The person signing this form is certifying that all documentation is enclosed which supports the Medicaid billed rates, units, and services.

Signature	Title
Telephone Number	

If you have any questions about this request or checklist, please contact reviewer listed above.

470-4479 (Rev. 4/11)

79.4(3) *Audit or review procedures*

- Records must be submitted within 30 days of written notification
- Extension of time limits:
  - For up to 15 days when:
    - Established good cause
    - Request received before deadline

79.4(3) *Audit or review procedures*

- Additional 15 day extension may be granted:
  - Established exceptional circumstances
  - Received before 15 day extension deadline

79.4(3) *Audit or review procedures*

- Announced or unannounced on-site reviews or audits are possible
- Review procedures may include
  - Comparing clinical record against claim
  - Interviewing members & staff
  - Examining TPL records
  - Comparing usual & customary fees

79.4(4) *Preliminary report of audit or review findings*

- If overpayment has occurred, a “preliminary report of a tentative overpayment” (PROTO) letter is issued
- Provider has opportunity to request reevaluation.

79.4(5) Disagreement with review findings

- Written reevaluation request received within 15 calendar days of notice date (PROTO)
- Provider can submit clarifying information or supplemental documentation within 30 days

79.4(6) Finding and order for repayment

- When reevaluation or expiration of deadlines has passed
- Order for repayment of over payment
- IME may withhold payments from other claims

Errors in Responding to Reviews

- Failure to submit docs timely per IAC 79.4
  - No documentation submitted at all
- Documentation submitted for wrong dates
- Submitted documentation not detailed enough
- Failure to submit all necessary documents, for example:
  - Individual Service Plans
  - Individual comprehensive plans
  - Signed documents

Documentation errors

- Illegible writing
- No begin/end times (when using a time defined code or otherwise required)
- Wrong code vs. service
- Documentation does not match services
- Invalid correction
- No signature or signature sheet

Documentation errors (continued)

- No dates of service
- Missing member response to interventions
- Physician orders not followed
- Documentation for tooth already removed
- DME-rent vs. purchase time frame

Self Assessments

- Quality assurance is in best interest of providers
- Value to providers of their own QA assessments:
  - Quickly ID narratives that are not adequate
  - Corrections can be made before claim submission
  - Quickly identify staff who need additional training

Medicaid Integrity & Federal Oversight

Office of inspector General (OIG)

- Protects the integrity of the Department of Health & Human Services (HHS) by combating fraud and abuse of HHS programs
- Performs audits and investigations in Medicare and Medicaid programs
  - Assists in developing cases of criminal, civil and administrative enforcement
  - Develops and distributes resources to assist the health care industry in complying with national fraud & abuse laws

Medicaid Fraud Control Unit(s) (MFCU)

- Investigate and prosecute Medicaid Provider fraud, patient abuse, & neglect within healthcare facilities
  - Receive referrals from Program Integrity
- Employs investigators, auditors, and attorneys
- Must comply with statutes, regulations, and OIG policy
- Iowa MFCU had 45 civil settlements/judgements in 2011

Medicaid Integrity Program (MIP) Overview

- CMS has two responsibilities under the Medicaid Integrity Program
  - Hire contractors to review Medicaid Providers
  - Provide support & assistance to States in combating fraud & abuse

Medicaid Integrity Contractor

- CMS program to audit providers enrolled with Iowa Medicaid
- MIC = Medicaid Integrity Contractor
  - Health Integrity, LLC-contracts with CMS
  - Communicates directly with chosen providers
  - Failure to comply with requests can result in claim recoupment
- IL #841- contains link to documents explaining the program

Payment Error Rate Measurement (PERM)

- Cycles every 3 years
  - Iowa review performed for fiscal year 2011
- CMS measures the error rate of Medicaid & CHIP payments

PERM (continued)

- 654 Medicaid claims selected totaling $1,958,812

- Errors identified as of 7/3/12:
  - 1 Data Processing error (data entry)
  - 14 Medical Review errors
    - $14, 297.09

PERM Errors

- Error types:
  - No documentation
  - Insufficient documentation
  - Diagnosis coding
  - Number of units

Iowa Administrative Code Summary

- Providers can develop a process or system of their own design
- Chosen system must demonstrate that Medicaid rules are met
- Providers should proactively review their current system to ensure IAC requirements are met

You Have Now Completed Documentation Standards 2012

Thank you

Questions?